

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

04948

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Edgar F. Bradley*

4. Sex	5. Color of race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *March 26 1871* 6. (c) If alive, give age years8. AGE: Years *74* Months *1* Days *12* If less than one day9. Birthplace *2nd* (Town, county, and state) *Rewell*10. Usual occupation *Retired Merchant*11. Industry or business *William C. Bradley*12. Name *William C. Bradley*13. Birthplace *Gloucester Co. N.J.*14. Maiden name *Emily Hopkins*15. Birthplace *Carolina Co. Md.*16. Informant *Edgar F. Bradley*Address *Sturlock*17. Burial Date thereof *May 11 1945* (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Bethel Cemetery*Location *New Sturlock*18. Funeral director *J. B. Villoughby*Address *Sturlock*19. Date signed by registrar *May 21 1945* *Chas W. Hastings* Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Dorchester*City or town *Sturlock* (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 9 - 1945* at *8:15 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 1944 to May 1945* and that I last saw him *alive* on *May 1945*.Immediate cause of death *exhaustion*

DURATION

Due to *Paralysis Agitans*

2 yrs +

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

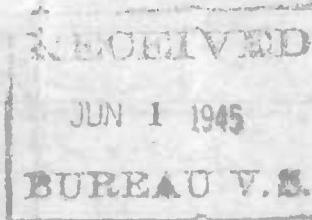
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *William C. Harrison MD* M. D. or otherAddress *Sturlock Md* Date signed *5/13/45*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1000

## CERTIFICATE OF DEATH

04949

Reg. Dist. No. 115

1. PLACE OF DEATH:  
 County Dorchester  
 City or town Fishing Creek  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution: home  
 Stay in hospital or Inst. (yrs., or mos., or days) —  
 Stay in this community (yrs., or mos., or days) life

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Fishing Creek Ward No. —  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. near 1st. Office (If rural give LOCATION)

3. (a) FULL NAME Raymond William Brinson Jr.  
 4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced singler  
 6. (b) Name of husband or wife no  
 7. Birth date of deceased (mo., day, yr.) May 23 - 1945  
 8. AGE: Years — Months — Days — If less than one day  
— — 1 hrs. 50 min.  
 9. Birthplace Fishing Creek, Md  
 (Town, county, and state)  
 10. Usual occupation infant - new born -  
 11. Industry or business  
 MOTHER FATHER  
 12. Name Raymond William Brinson  
 13. Birthplace Tampa, Fla  
 14. Maiden name Sula Meace Creighton  
 15. Birthplace Fishing Creek, Md.  
 16. Informant Sula M. Brinson  
 Address Fishing Creek, Md  
 17. Burial Date thereof May 24 - 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Honor Memorial Cemetery  
 Location Fishing Creek, Md  
 18. Funeral director Mildred Creighton  
 Address Fishing Creek, Md  
 19. May 24 1945 J. Meace Meace  
 (Date rec'd by registrar) Coca Registrar

3. (b) Social Security Number 45

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 23 1945, at 10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 23 1945, to May 23 1945,  
 and that I last saw him alive on May 23 1945.

Immediate cause of death Premature Birth DURATION  
Past three gest about 4 months

Due to Premature Rupture Membrane

Due to Other cause unknown  
independly spontaneous

Other conditions none

(Include pregnancy within 3 months of death)

Major findings:  
 Df operations X

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

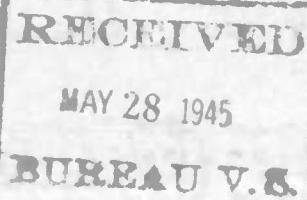
Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Jane A. Meace May

M. D. or other

Address Fishing Creek, Md Date signed May 28 1945



1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

04950 115

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Dorchester

City or town.....

Fishing Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Eliza Creighton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

June 7-1865

8. AGE:

Years

Months

Days

If less than one day

79

11

22

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Fishing Creek

10. Usual occupation.....

Housekeeper

11. Industry or business

George E. Creighton

12. Name.....

Dr. G.

13. Birthplace

Anne Eliza Wallace

14. Maiden name.....

Dr. Co.

15. Birthplace

Mrs. Anna J. Creighton

16. Informant.....

Fishing Creek

Address.....

Burial

Date thereof 5/31-45  
(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Hoosier M.E.

Cemetery or crematory

Location.....

Fishing Creek

18. Funeral director.....

Kenneth P. Thomas

Address.....

Cambridge, Md.

19. May 30 1945

(Date rec'd by registrar)

1945

Name of Measles

Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Fishing Creek (If outside city or town limits, write RURAL and give nearest town)

Street No.....

none (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 29 19..... at 12:30<sup>1</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 15 1945 to May 29 1945

and that I last saw her alive on May 29 1945

Immediate cause of death.....

Chronic hepatitis

DURATION

10 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

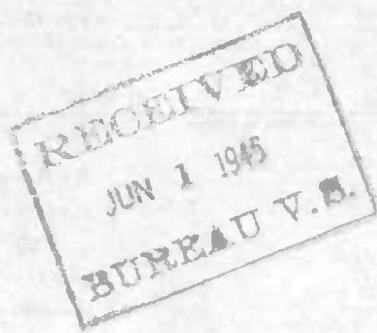
James W. Mease M.D.

M. D. or other

Address.....

Fishing Creek, Md.

Date signed May 30 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

04951

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County

Dorchester

City or town

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Greene, Cornish

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Boland married

8.(b) Name of husband or wife

Geo. Cornish

7. Birth date of deceased (mo., day, yr.)

Greene Cornish 6. (c) If alive, give age 50 years  
7 7 1896

8. AGE:

Years

Months

Days

If less than one day

49

hrs.

min.

9. Birthplace

Maryland - Bel Air

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

horse

MOTHER

12. Name

Unknown

FATHER

13. Birthplace

Maryland

MOTHER

14. Maiden name

Unknown

MOTHER

15. Birthplace

Unknown

16. Informant

Geo. Cornish

Address

231 Cedar St.

17. Burial Cemetery  
(Burial, cremation, or removal. Which?)Date thereof May 27 th  
(month) (day) (year)

Cemetery or crematory

Bethel A. M. E. Cemetery

Location

Cambridge

18. Funeral director

Rev. J. H. Blayden

Address

201 Wash. St. Camb. Md.

19. Death certificate

May 26 1955 John MacJ. Md.

(Date recd. by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Maryland Dorchester

City or town

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

231 Cedar St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 24

1945 at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1945 to May 24 1945 and that I last saw her alive on May 24 1945.

Immediate cause of death

Cardiac Arrest

DURATION

5 days

Due to Ben Hypertension

1945

Due to

Other conditions Heart trouble

19 days

Tonsilitis

6 days

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

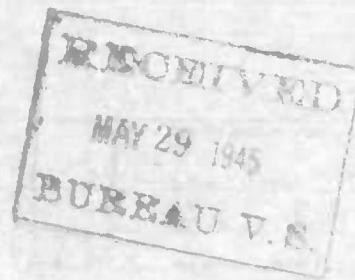
Means of injury

Injured at work?

23. SIGNATURE Carol M. O'Leary

M. D. or other

Address On Cedar St Date signed May 25 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-10

## CERTIFICATE OF DEATH

04952

Reg. Date No. 110

## 1. PLACE OF DEATH:

County.....

Dorchester

City or town.....

Galeston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

49 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Joseph H. Ellis

4. Sex

5. Color or race

6. (e) Single, married, widowed, or divorced

M

White

Married

6. (b) Name of husband or wife.....

S. Vesta Ellis

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1862

6. (c) If alive, give age ..... years

8. AGE:

Years  
82Months  
5Days  
4If less than one day  
hrs. .... min.

9. Birthplace.....

Dorchester Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Joseph Ellis

12. Name.....

Del

13. Birthplace

Eliza J. Hearne

14. Maiden name.....

Del

15. Birthplace

Seaford, Del.

16. Informant.....

Vesta Ellis

Address

Seaford, Del.

R.D.

17. Burial, cremation, or removal (which?)

Burial

Date thereof.....

5-27-1945

(month) (day) (year)

Cemetery or crematory.....

Galeston

Location.....

Gravemors Bros

18. Funeral director.....

Sharptown Md

Address

Howard &amp; Higgins

19. (Date rec'd by registrar)

L.L. Hastings

19. 5/27

1945

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Dorchester County.....

City or town..... Near Galeston, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24 1945, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1943 to May 24 1945 and that I last saw him alive on April 29 1945

Immediate cause of death.....

Chronic Endocarditis

DURATION

10 yrs?

Due to.....

Due to.....

Other conditions..... arterios - Proctitis ?

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

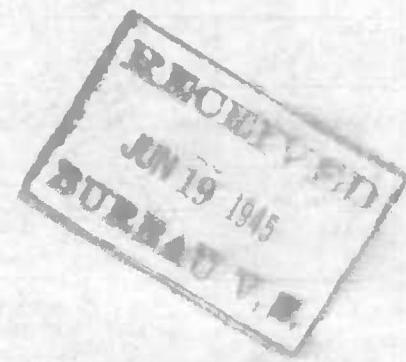
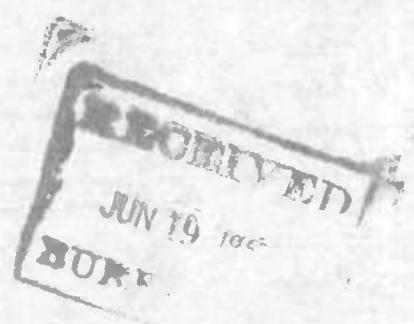
Injured at work? .....

23. SIGNATURE..... Howard &amp; Higgins

M. D. or other

Address..... Sharptown

Date signed 5/26/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

Reg. Dist. No.

04953, 15

1. PLACE OF DEATH: Dorchester  
 County Fishing Creek  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? entire life  
 Hospital, institution, or street address where death occurred: home  
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Fishing Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Near Post Office (If rural, give LOCATION)

3. (a) FULL NAME  
Edua H. Flowers

3. (b) Social Security Number  
no -

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Thomas H. Flowers  
 7. Birth date of deceased (mo., day, yr.) July 19 - 1895 6. (c) If alive, give age 50 years

8. AGE: Years 49 Months 9 Days 22 If less than one day  
 hrs. ..... min. ....

9. Birthplace Fishing Creek  
 (Town, county and state)

10. Usual occupation Housewife

11. Industry or business Geo. Wm. Hall

12. Name Hector Co

13. Birthplace Susan E. Jolley

14. Maiden name Hector Co

15. Birthplace Mrs Allen R. Adams

16. Informant Cambridge, Md.  
 Address

17. Burial Hoosier Memorial  
 Date thereof May 13-1945  
 (Burial, cremation, or removal. Which?) Cemetery or crematory

Location Fishing Creek

18. Funeral director Kenneth R. Thomas

Address Cambridge, Md

19. May 12 1945  
 (Date rec'd by registrar)

*James T. Meade*  
 LOCAL Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to May 11 1945 and that I last saw her alive on May 11 1945

Immediate cause of death Carcinoma of breast DURATION 12 mos.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. No op.

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

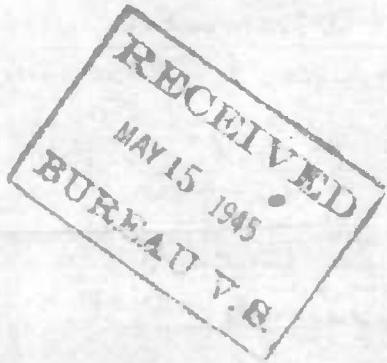
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work? .....

23. SIGNATURE James T. Meade M.D. M. D. or other .....

Address Fishing Creek, Md. Date signed May 12/45





PLEASE WRITE PLAINLY,  
WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

04954

Reg. Dist. No. 116

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Dorchester  
City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 

Hospital, Institution, or street address where death occurred:

Barracks near Factory C. - Phillips Packing Co.

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel Gadsden

## 3. (b) Social Security Number

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

male      colored      single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1921

8. AGE: Years      Months      Days      If less than one day  
24      1      8      hrs.      min.9. Birthplace.....  
(Town, county, and state)  
South Carolina

10. Usual occupation.....

Laborer

11. Industry or business.....

General

12. Name..... Lonnie Gadsden

13. Birthplace..... South Carolina

14. Maiden name..... May Gadsden

15. Birthplace..... South Carolina

16. Informant..... Records of Phillips Packing Co

Address Cambridge, Md.

17. Burial, cremation, or removal. Which? Date thereof..... 5-30-45  
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Mount City

Location.....

Cambridge, Md.

18. Funeral director..... Lewis H. Baughman

Address.....

Cambridge, Maryland

19. Date rec'd by registrar..... May 25, 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Park Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... May 23 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

X 19..... to X 19.....

and that I last saw h. X alive on X 19.....

Immediate cause of death.....

Pistol Shot wounds of  
Chest and Abdomen

DURATION

-

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... homicide Date of May 23/45

Where did injury occur?..... Cambridge - Dor. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Workers barracks

Means of Injury..... pistol

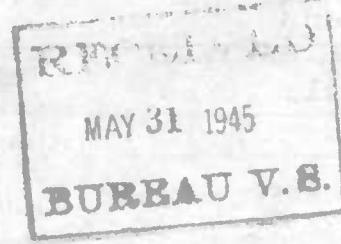
Injured at work? no

23. SIGNATURE

Joe K. Shriver, Doy. Med. Exan.

M. D. or other

Address..... Cambridge, Md. Date signed..... May 24/45



1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13<sup>th</sup>

## CERTIFICATE OF DEATH

04955

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County.....

Dorchester

City or town.....

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

22 years

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles H. Triplett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

married

6.(b) Name of husband or wife.....

Alvina Peters

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

April 7, 1867

8. AGE:

Years

Months

Days

If less than one day

78

1

15

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Germany

Farmer, retired

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Lubbock

Germany

MOTHER

13. Birthplace.....

Lorraine Koloff

14. Maiden name.....

Germany

15. Birthplace.....

Mrs. Charl H. Triplett

Cambridge Md.

16. Informant.....

Address

Burial

Date thereof.....

5/24/45

(Burial, cremation, or removal. Whence)

Cemetery or crematory

East New Market

Location

East New Market Md

18. Funeral director

Kenneth R. Shew

Address

Cambridge, Md.

19. Date rec'd by registrar

May 24-45

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Dorchester

City or town.....

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

106

Pearlblown Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 22 1945 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 1945 to May 22 1945

and that I last saw him alive on May 20 1945

Immediate cause of death arteriosclerosis

Cardio-vascular

Renal Disease

DURATION

?

Due to.....

Due to.....

Other conditions Cerebral accident Oct. 1940

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

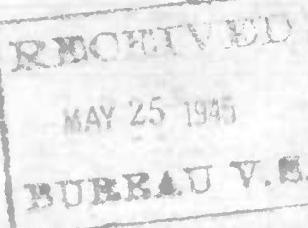
Injured at work?

23. SIGNATURE.....

M. D. or other

Eldridge H. Welford

Address..... Cambridge, Md. Date signed 5-23-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-4

04956 T

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County..... Dorchester  
City or town..... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 year  
Hospital, institution, or street address where death occurred:  
..... 134 Mill St.  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Dorchester  
City or town..... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 134 Mill St.  
(If rural, give LOCATION)

3. (a) FULL NAME..... M. Warren Hooper  
4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
6. (b) Name of husband or wife..... Annie L. Jones  
7. Birth date of deceased (mo., day, yr.)..... March 30, 1872. 6. (c) If alive, give age..... 72 years  
8. AGE: Years..... 73 Months..... 1 Days..... 4 It less than one day..... hrs. ..... min.  
9. Birthplace..... Hoopers Island, Dor. Co., Md.  
(Town, county, and state)  
10. Usual occupation..... Retired  
11. Industry or business..... Merchant  
MOTHER FATHER  
12. Name..... Matthew T. Hooper  
13. Birthplace..... Maryland  
MOTHER  
14. Maiden name..... Julian A. Meekins  
15. Birthplace..... Maryland  
16. Informant..... Mrs. Annie J. Hooper  
Address..... 134 Mill St., Cambridge, Md.  
17. Burial..... Date thereof May 7, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Cambridge Cemetery  
Location..... Cambridge, Maryland  
18. Funeral director..... LeCompte Funeral Service  
Address..... Cambridge, Maryland  
19. May 7-1945 John MacL. M.D.  
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 4, 1945, at 8: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25, 1945, to May 4, 1945,  
and that I last saw her alive on May 1, 1945.

Immediate cause of death.....

Physical condition - Chronic

DURATION

Due to..... Anemia -

?

Due to.....

Other conditions..... Asthma Chronic

several years

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell to the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Dr. K. Shriver, M.D.

M. D. or other

Address..... Cambridge, Maryland Date signed May 7, 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04957

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred: Cambridge Mary 1 and Hospital Inc

How long in hospital or institution? 12 days

## 3. (a) FULL NAME

Augusta Matthews

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6. (b) Name of husband or wife: \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Dec 1st 1883

8. AGE:	Years 62	Months	Days	If less than one day
				hrs. .... min.

6. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House work

## 11. Industry or business

12. Name: Matt Pinder

13. Birthplace: Maryland

14. Maiden name: Mary Johnson

15. Birthplace: Maryland

16. Informant: Hattie Matthews

Address: East New Market

17. Burial Date thereof: May 17 1945  
 (Burial, cremation, or removal, which?)

Cemetery or crematory: Cemetery

Location: East New Market

18. Funeral director: A. B. Willow &amp; Son

Address: East New Market

19. Date record by registrar: May 16 1945  
 (Date record by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)Street No.: 12 Pine Street  
 (If rural, give LOCATION)

2. (a) If veteran, name war: \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945 at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15 1945 to May 14 1945, and that I last saw her alive on May 14 1945.

Immediate cause of death: Malaria

Due to: Chronic nephritis

DURATION

2 day

Due to: Chronic cardiac valvular disease

1 year

Other conditions: Chronic cardiac valvular disease

5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_

Date of op.: \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

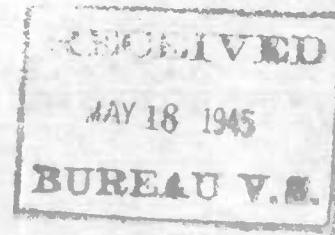
Means of injury: Injured at work

23. SIGNATURE: Elmer Byrd, M.D.

M. D. or other: M.D.

Address: 37 Ross St., Cambridge, Md.

Date signed: 5-15-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 192

84958

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester

City or town Cambridge RFD # 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Home RFD # 2

How long in hospital or institution?

## 3. (a) FULL NAME

John R. Mills, Jr.

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 17, 1906

6.(c) If alive, give age years

## 8. AGE:

Years  
39Months  
2Days  
1

If less than one day

hrs.

min.

9. Birthplace Church Creek, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Dirt

12. Name John R. Mills

13. Birthplace Maryland

14. Maiden name Katie Hall

15. Birthplace Maryland

16. Informant Mrs. Katie Mills

Address RFD # 2, Cambridge, Md.

17. Burial Date thereof May 21, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. May 21<sup>st</sup> 45 (Date rec'd by registrar)

Registrat

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Rural--Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

X 19. to X 19.

and that I last saw h. X alive on X 19.

Immediate cause of death

Lightning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 18/45

Where did injury occur? Bucktown (City or town) Dor. (County) Md. (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Lightning Injured at work Yes

23. SIGNATURE Dr. H. Shriver, D.P.M. Exam.

M. D. or other

Address Cambridge, Md. Date signed May 21/45

RECEIVED

MAY 25 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

## CERTIFICATE OF DEATH

04959

Reg. Dist. No. 64 116

## 1. PLACE OF DEATH:

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cambridge - Maryland Hospital

(3 weeks) 2 days

How long in hospital or institution?

## 3. (a) FULL NAME

Elizabeth Parker

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Levin Parker

7. Birth date of deceased (mo., day, yr.)

April 27, 1911

6. (c) If alive, give age 39 years

8. AGE:

Years  
34Months  
0Days  
6It less than one day  
hrs.  
min.

9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

12. Name

Thomas Adams

13. Birthplace

Dorchester County, Maryland

14. Maiden name

Emma Pinkett

15. Birthplace

Dorchester County, Maryland

16. Informant

Levin Parker

Address

Hullock, Maryland, P.T.D.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof May 6 1945

(month) (day) (year)

Cemetery or crematory

Washington Cemetery

Location

Near Hullock, Maryland

18. Funeral director

J. J. Frampton &amp; Son

Address

Tidewater, Maryland

19. Date rec'd by registrar

May 5 1945

S. S. Frampton

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Hullock - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Near Haddells Corner

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1945 to May 3 1945

and that I last saw her alive on May 2 1945

Immediate cause of death

Probable Brain abscess

DURATION 2 wks.

Due to Meningococcic Meningitis

4 wks.

Due to

Other conditions Syphilis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William C. Harrison MD M. D. or other

Address Hullock Md Date signed 5/5/45

M

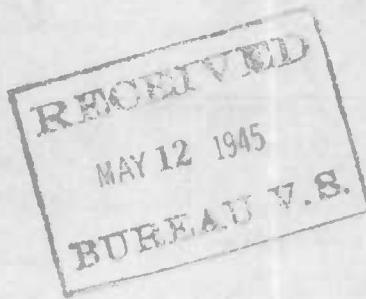
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1520

04960

## CERTIFICATE OF DEATH

Reg. Dist. No. 110 119

1. PLACE OF DEATH:  
County Dorchester  
City or town Wingate  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred: Wingate  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Dorchester  
City or town Wingate  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Wingate  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Barbara Ann Parks

## 3. (b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
---------------	------------------------	----------------------------------------------------

6.(b) Name of husband or wife (Infant)

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1944.  
6.(c) If alive, give age years

8. AGE: Years - Months 6 Days 23 If less than one day hrs. min.

9. Birthplace Cambridge, Dor. Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Asbury George Parks

13. Birthplace Maryland

14. Maiden name Rosalie Willey

15. Birthplace Maryland

16. Informant Mrs. A. G. Parks

Address Wingate, Maryland.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 7, 1945  
(month) (day) (year)

Cemetery or crematory Bloodsworth Cemetery

Location Wingate, Maryland

18. Funeral director LeCompte's Funeral Service  
Address Cambridge, Md.19. May 6, 1945 William D. Pritchett  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945 at 6-45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

Congenital Malformation  
of Heart

Due to

Due to

Other conditions Bronchitis severe  
with a goiter

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

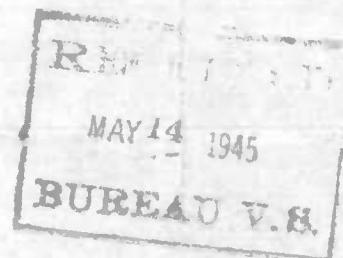
Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cambridge, Md. Date signed May 6, 1945



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

04961

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County DorchesterCity or town Williamsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Stephen Pinder

## 4. Sex

Male

## 5. Color or race

Colored

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

Mary Pinder

## 7. Birth date of deceased (mo., day, yr.)

About 1880

6.(c) If alive, give age years

## 8. AGE:

Years About 65

Months -

Days -

If less than one day hrs. min.

## 9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

## 10. Usual occupation

Day laborer

## 11. Industry or business

Farming

## 12. Name

Emory Pinder

## 13. Birthplace

Dorchester County, Maryland

## 14. Maiden name

Minta

## 15. Birthplace

Dorchester County, Maryland

## 16. Informant

Nettie Lake

## Address

Williamsburg, Maryland

## 17. Burial

Date thereof May 29 1945

(Month) (day) (year)

## (Burial, cremation, or removal. Which?)

Cemetery or crematory Washington Cemetery

## Location

Near Harlock, Maryland

## 18. Funeral director

J. J. Frampool &amp; Son

## Address

Federalsburg, Maryland

19. May 29-1945  
(Date rec'd by registrar)Chas. W. Hastings  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty DorchesterCity or town Williamsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 27 1945 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1945 to May 1945

and that I last saw him alive on May 26 1945

## Immediate cause of death

Chronic myocardial

dysfunction

arteriosclerosis

## Due to

old age

## DURATION

5 yrs +  
5 yrs +

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

W.C. Harrison MD

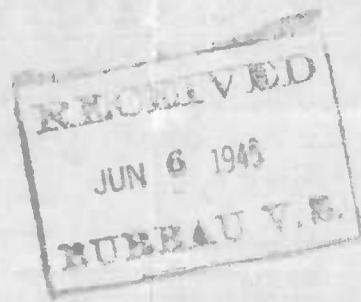
M. D. or other

Address

Harlock, MD

Date signed

5/29/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

04962

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County Dorchester

City or town Mr. Hoopers Island  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:

Drowned In Chesapeake Bay

How long in hospital or institution? —

3. (a) FULL NAME  
William Thomas Pittman

4. Sex Male | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1912.  
6.(c) If alive, give age — years

8. AGE: Years 33 Months 4 Days 15 If less than one day hrs. min.

9. Birthplace Gates, RFD # 2, North Carolina  
(Town, county, and state)

10. Usual occupation Mariner

11. Industry or business United States Navy

12. Name Unknown

13. Birthplace II

MOTHER FATHER 14. Maiden name Altah Pittman

15. Birthplace Unknown

16. Informant J. E. Agar, Pharmacist Mate

Address Chincoteague, Virginia

17. Burial Date thereof June 7, 1945.

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gates Cemetery

Location Gates, North Carolina

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. *James J. Meehan* John Meehan, M.D.  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State North Carolina County

City or town Rural - Gates  
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw h. X alive on 7 19.

Immediate cause of death: Drowning

Due to: Drowning

Due to: Drowning

Other conditions: Drowning

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 17, 1945.

Where did injury occur? In Chesapeake Bay (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) On a boat

Means of injury drowning Injured at work? Yes

23. SIGNATURE: Dr. K. Shriver, Del Mo. Exam. M. D. or other

Address: Cambridge, Md. Date signed May 3, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(R.R.)*

04963

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:  
Dorchester  
County

City or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

25 Years

How long in above place of death?

Hospital, Institution, or street address where death occurred:  
325 Henry St.,

How long in hospital or institution?

3. (a) FULL NAME  
Sarah Adams Seward

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... George H. Adams  
(Deceased)

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1867.

8. AGE:	Years	Months	Days	If less than one day
	78	2	20	hrs. min.

9. Birthplace..... Taylors Island, Dor. Co., Md.  
(Town, county, and state)

10. Usual occupation..... None  
11

11. Industry or business

FATHER 12. Name..... Josiah Moore

MOTHER 13. Birthplace..... Maryland

14. Maiden name..... Sarah E. Moore

15. Birthplace..... Maryland

16. Informant..... Mrs. Arnold E. Elsey

Address 325 Henry St., Cambridge, Md.

Burial 17. Date thereof May 3, 1945.  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cambridge Cemetery

Location Cambridge, Maryland.

18. Funeral director..... LeCompte's Funeral Service

Address Cambridge, Maryland.

19. Date record by registrar  
May 3 - 1945 John Mac G. Mc

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Henry St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 16, 1945, to May 1, 1945, and that I last saw her alive on May 1, 1945.

Immediate cause of death Myocardial Failure DURATION

Due to Insuuration

Due to Senility

Other conditions Fracture Right Arm  
Diseases Accidental Fall, Age 80  
(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following

Accident, suicide, or homicide..... Accident Date of February 16, 1945

Where did Injury occur? Henry Street, Cambridge, Dorchester Co., Md.

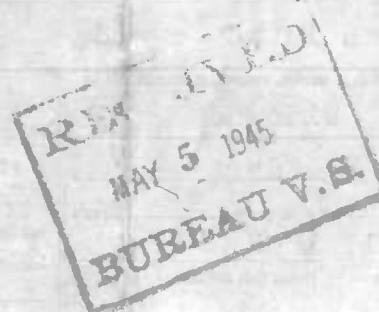
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Outside

Means of Injury Accidental fall. Injured at work?

23. SIGNATURE J. J. Elsey M. D. or other

Address Cambridge, Md. Date signed May 2, 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04964

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH:  
County Rochester  
City or town Secretary

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George B. Stone

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

aug 21 1863

8. AGE:

Years

Months

Days

If less than one day

82 80 9

hrs. min.

9. Birthplace

(Town, county, and state)

New York

10. Usual occupation

writer

11. Industry or business

Edgar G. Stone

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

H. P. Stone

16. Informant

George B. Stone

Address

Secretary

Burial

(Burial, cremation, or removal. Which?)

Date thereof May 16 1945

(month) (day) (year)

Cemetery

Cemetery

Location East New Market

F. B. McLaughlin

18. Funeral director

Address East New Market

19. (Date rec'd by registrar) 19.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Secretary

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 18.....

and that I last saw h..... alive on..... 18.....

Immediate cause of death.....

Coronary Occlusion

Due to..... Arterio - sclerosis ?

Due to.....

Other conditions Gangrene - left foot 2 wks

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE Joe K. Shriver, Dep. Med. Exam.

M. D. or other

Address Cambridge Ma Date signed May 15 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-34

## CERTIFICATE OF DEATH

04965

Reg. Dist. No. 112

1. PLACE OF DEATH:  
County... Dorchester

City or town... Princiana  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME  
John Theodore Tare

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

B.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) May 8 1866 8. (c) If alive, give age years

8. AGE: Years 79 Months 3 Days 6 If less than one day  
hrs. min.

9. Birthplace Princiana Town, county, and state

10. Usual occupation Retired

11. Industry or business Samuel Payton Tare

MOTHER FATHER 12. Name Samuel Payton Tare

13. Birthplace Princiana

14. Maiden name Catherine Carroll

15. Birthplace Princiana

16. Informant Ms. John D. Tare

Address Princiana

17. Burial, cremation, or removal? Which? Burial Cemetery Date thereof May 17 1945  
(month) (day) (year)

Cemetery or crematory Princiana

Location Princiana

18. Funeral director J. B. Tiffey

Address East New Market,

19. May 17 1945  
(Date record by registrar)

Elizabeth D. Braggs  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State ..... County .....

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No. .... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 15 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1943 19... to May 13 19...  
and that I last saw him alive on May 13 19...

Immediate cause of death

Chronic myocardial  
degeneration

Due to arteriosclerosis DURATION

Due to

Other conditions Chronic Colitis 10 yrs +

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

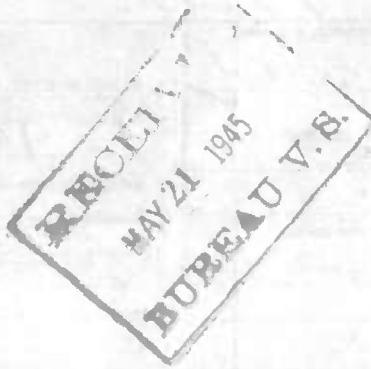
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Harrison MD M. D. or other

Address Kentucky Md. Date signed 5/17/45







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

4967  
110

Reg. Dist. No.....

1. PLACE OF DEATH: Dorchester  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Elijah H. Sheddleton

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

8. (b) Name of husband or wife Sara E.

7. Birth date of deceased (mo., day, yr.) Jan 27 1871 6.(c) If alive, give age 54 years

8. AGE: Years 74 Months 3 Days 19 It less than one day hrs. .... min.

9. Birthplace Preston Carolina Md  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business William Sheddleton

MOTHER FATHER	12. Name..... <u>William Sheddleton</u>
	13. Birthplace <u>Md</u>
MOTHER	14. Maiden name <u>Mary A. Griffith</u>
	15. Birthplace <u>Md</u>
	16. Informant <u>William L Sheddleton</u>
	Address <u>Seaford, Del. R.D.</u>

17. Burial Burial Date thereof 5-18-1945  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Galestown

Location Graverow Bros  
 18. Funeral director Sharptown Md

Address Sharptown Md  
 19. 5-18 19. 45 Bob Hastings  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 19. 45, at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7, 1945 to May 16 1945 and that I last saw him alive on May 16 1945

Immediate cause of death Allected mellitus DURATION Unknown

Due to.....

Due to.....

Other conditions Atherosclerosis DURATION Unknown

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE Brutelop M.D. or other M.D.M. D. or other M.D.Address Bridgeton, Del. Date signed 5/19/45



PLEASE WRITE PLAINLY, WITH UXFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

04968 T

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester

City or town Cambridge Route 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? September

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ernest Frederick Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

October 7 1944

8. AGE:

Years	Months	Days	If less than one day
7	28	hrs.	min.

9. Birthplace

Cambridge MD Route 3

(Town, county, and state)

10. Usual occupation

none

## 11. Industry or business

12. Name Ernest Wilson

13. Birthplace Cambridge MD

14. Maiden name Ada Banks

15. Birthplace Church Creek MD

Ada Wilson

16. Informant

Address Cambridge Route 3 MD

17. (Burial, cremation, or removal. Which?) Date thereof May 8 1945

(month) (day) (year)

Cemetery or crematory Reck Neck

Location Reck

18. Funeral director Lewis H. Baumgardner

Address Cambridge MD

May 5 1945

(Date rec'd by registrar)

19. For John Macfie M. D. or other

Registrar

Address One Tide Rd

Date signed 3-3-45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Cambridge MD Route 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5

1945 at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 21 1945 to May 5 1945

and that I last saw him alive on May 4 1945

Immediate cause of death

Bronchopneumonia  
(Oxymy)

DURATION

18 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll M. St. Clair M.D.

M. D. or other

Address One Tide Rd

Date signed 3-3-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 16

04969

1. PLACE OF DEATH:  
County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
Carteret-Maryland Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Baltimore  
City or town Baltimore MD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. no  
(If rural, give LOCATION) Street No. no

3. (a) FULL NAME  
James Woodford

3. (b) Social Security Number  
no

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Jennie Woodford  
7. Birth date of deceased (mo., day, yr.) July 1888 6. (c) If alive, give age 90 years  
7. Birth date of deceased (mo., day, yr.) July 1888 6. (c) If alive, give age 90 years  
8. AGE: Years 57 Months 0 Days 0 If less than one day  
hrs. 0 min. 0

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Same as above  
MOTHER FATHER 12. Name Fortino Woodford  
13. Birthplace Baltimore Anne  
14. Maiden name Jennie Brile  
15. Birthplace Baltimore Anne MD

16. Informant Haylor Woodford

Address Baltimore MD

17. Burial Burial Date thereof May 20 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location near Princess Anne MD

18. Funeral director James F. Stewart

Address Baltimore MD

19. May 20, 1945  
(Date record by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/45 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/16/45 to 5/17/45 and that I last saw him alive on 5/17/45.

Immediate cause of death Myocardial Failure DURATION 2 days

Due to Arterio sclerotic CARDIOSCLEROSIS duration ?

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of ....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE James Moore Jr. 1946 M. D. or other

Address Baltimore MD Date signed 5/18/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 04970

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Single

## 6. (b) Name of husband or wife

Dec 11 1919

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Dec 11 1919

## 8. AGE: Years Months Days If less than one day

25 5 19 hrs. min.

## 9. Birthplace (Town, county, and state)

Cambridge mdHouse Woods

## 10. Usual occupation

## 11. Industry or business

Joseph WoolfordBathhouse keeperShirley ShirleyState of MdJoseph WoolfordCambridge, mdBurial

(Burial, cremation, or removal, which?)

Date thereof June 1 1945  
(month) (day) (year)CemeteryBethel Cemetery CambridgeSewell St. Body roomAddressCambridge, mdMay 31 1945 John Mace J. mo

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Carroll

City or town

Chisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Edgewood Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1945 at 5:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1945 to May 30 1945, and that I last saw her May 24 1945 alive on May 24 1945.

Immediate cause of death

Gulmonary EdemaDue to Charley Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carrie M. H. C. M. D. or otherAddress One Park St. Date signed 1-30-45

